OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Northern Virginia Mental Health Institute

James W. Stewart, III
Inspector General

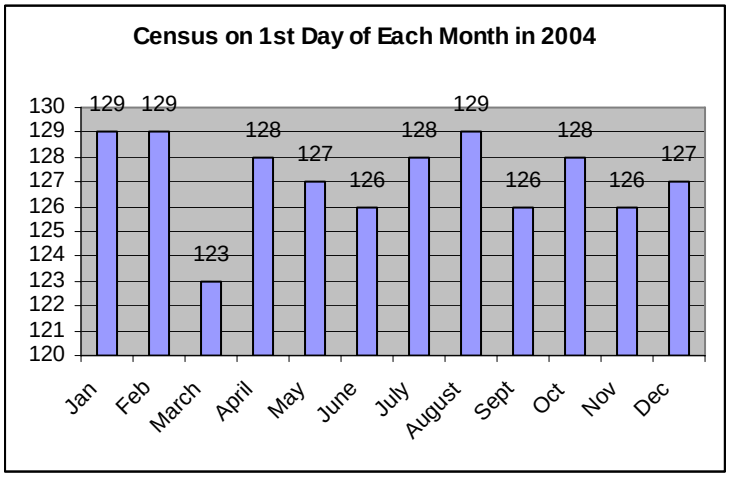
Report #113-05

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
FALLS CHURCH, VIRGINIA
February 23 & 24, 2005
OIG Report #113-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Virginia during February 23 -24, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Central Office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 28 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 8 consumers. Documentation reviewed included, but was not limited to, 4 clinical records, selected policies and procedures, staff training curricula, the facility quality management plan, and risk management reviews. A tour of the facility was conducted. Graphs in this report were created from data provided by the facility.

BACKGROUND: NVMHI is a facility operated by DMHMRSAS that provides services to adults between the ages of 18 and 64. The facility is the primary state hospital for five community services boards, including Fairfax-Falls Church, Arlington, Alexandria, Loudon and Prince William. The facility's operating capacity was reported to be 129 beds. At the time of the inspection, the facility had a census of 127 consumers. The census on the 1st day of each month for 2004 was as follows:



The budget for this facility in FY 2004 was $24,460,278 with reported expenses for the same period of $24,460,238. The facility budget for FY 2005 is $24,026,470. This represents a decrease in funding from the actual expenses of the previous fiscal year of $433,768. The facility reported that the cost per bed day was $534.19.

MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

Administrative, clinical and direct care staff had a working knowledge of the facility's mission and values. It was reported that the mission statement is reviewed with new employees by the facility director during their initial orientation and annually thereafter. Copies of the mission statement were posted throughout the facility. It was reported that the mission was formally revised three years ago but undergoes an annual review.

The mission statement for NVMHI reads:

> *Our mission is to support the recovery of individuals with serious mental illness through the delivery of safe, efficient and effective treatment and rehabilitative services.*

The organizational values include:

- *Patient centered quality services*
- *Teamwork*
- *Respect*

The staff interviewed reported that the following values guide how the facility operates: treatment with dignity and respect, teamwork, professionalism, cooperation, communication and confidentiality.

2. The facility has a strategic plan.

Administrative staff reported that strategic planning within the facility occurs on a two-year cycle, with an annual review of the established goals by the leadership team. The strategic planning process involves staff on all levels and in all disciplines. One of the primary objectives of the facility in creating the most recent strategic goals was to align future planning strategies with the facility budget.

Four primary goals are identified in the 2005 Strategic Plan. The goals include:

1. Create a culture and service delivery framework that embraces recovery principles.
2. Assure the recruitment, development, and retention of a productive and satisfied workforce that embodies the NVMHI mission and contributes to the attainment of our vision.

3. Promote patient and staff safety, and effectively limit and manage risks.
4. Establish a leadership role in the regional delivery system of care.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff indicated that the facility's mission and strategic plan were not specifically reviewed following the adoption of the DMHMRSAS vision statement because they were already well aligned with the vision statement that also emphasizes recovery, safety, efficiency and effectiveness.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

NVMHI has a number of systems in place to monitor the effectiveness of the services provided. Reviews occur on the organizational level through various committees, performance improvement initiatives and quality assurance activities. Effectiveness measures are also established within the various disciplines. The facility director reported that she monitors the facility data dashboard that reports on such indicators as the number and type of consumer complaints, the number of abuse and neglect investigations, the use of IM medications, the number of admissions, discharges and the average length of stay for the consumers.

The facility has established the following 4 hospital-wide performance improvement goals/activities for FY 2005:

- Improve the efficiency and effectiveness of clinical treatment
- Improve communications among all staff, with special emphasis on clinical communication
- Improve ways to address patient aggression
- Improve educational offerings at the hospital

Administrative staff reported that efficiency is measured within the context of the budget. This involves an ongoing review of measures such as the use of overtime, the number of vacancies in direct care positions, and the impact of diverting resources to direct services.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

At the time of the inspection, there were 364 approved full-time positions, of which 300.6 were filled. Of these positions, 79 of 85 human service care worker positions and 61.5 of 78 RN I/RN II positions were filled on the first day of the inspection. This count does not include the 13 RN supervisory positions.

Among the clinical staff positions at NVMHI are the following:

- 8 FT psychiatrists, including the Medical Director and 2 PT contractual medical doctors.
- 9 FT psychologists, including the director. All have a PhD.
- 12.6 FT social workers, including the director. All but one is a licensed clinician (LCSW). The remaining social worker is a licensed eligible Master's level clinician.
- 13 FT activity therapists, not including the supervisory positions. These include 6 occupational therapists, 3 art therapists, and 4 recreational therapists.
- 3 pharmacy staff including a supervisor, a pharmacist and a pharmacy assistant.
- 1 FT nutritionist.

The direct care positions, including human service care workers and nurses, have traditionally been the positions that are the hardest to fill at this facility. It was reported that the average salary for the recently hired direct care positions was human service care worker ($22,803), RN I ($45,031), and RN II ($51,014). Administrative staff reported that every attempt is made to negotiate salaries with the selected RN applicants, however, current budget constraints have made it increasingly difficult to fill RN I and RN II vacancies. Data revealed that since the beginning of FY 2005, 7 RNs declined to accept the offers because the facility was not able to meet the salary requirements. The facility reported that several of the recent applicants for RN I positions were making $8,000 more in the positions they held in other community settings than the current RN II entry-level salary offered at NVMHI.

Nursing administrative staff indicated that a number of factors were reviewed in determining the appropriate number of staff for any given shift. The factors include, but are not limited to, the established minimum consumer to staff ratios, patient acuity, number of scheduled appointments and number of persons on special observation status.

Staffing patterns for registered nurses (RN), licensed practical nurses (LPN) and direct service associates (DSAs) for February 23, 2005 were as follows:

F Unit: 4 RNs and 3 DSAs for a census of 21 consumers.

I-1 Unit: 3 RNs, 1LPN and 5 DSAs for a census of 29 consumers. One consumer was on a limited 1:1 staffing ratio. Two DSAs were working overtime.

I-2 Unit: 4 RNs, 1 LPN and 4 DSAs for a census of 31. One consumer was on 1:1.

K Unit: 4 RNs, 1 LPN and 7 DSAs for a census of 44. One consumer was required 1:1 staff supervision while attending the treatment mall activities.

The facility assures that staff is qualified to perform assigned duties beginning with the application and screening process. Selection criteria are established for each position. There is a careful screening of all applicants to assure that knowledge, skills and abilities match these criteria. It was reported that most interview processes involve the use of scenarios in order to gain some information regarding the applicants' orientation to service provision and procedures. Performance expectations are reviewed during the initial orientation process so that staff has a clear understanding of their duties. There is an extensive orientation process (30 days) for direct care staff, which includes classroom instruction and on-unit training. Annual training that reviews key policies and procedures is required.

Areas of required competency are established for all direct care and clinical positions. Staff is expected to pass written tests or be able to demonstrate competency with key tasks. Staff skills are enhanced through peer review and the fulfillment of educational requirements for licensed practitioners.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative staff reported that the facility director has communicated a clear expectation that every person on the senior leadership team is to bring the voice of their staff to the leadership meetings. This is accomplished through regular departmental meetings. Ideas and comments regarding the facility's strategic plan, performance improvement initiatives and clinical practices are routinely elicited. It was reported that clinical department heads are in the process of seeking feedback from their staff regarding ways to infuse the recovery model into day-to-day activities within the hospital.

Eleven of the 12 direct care staff interviewed outlined the following ways in which they are given the opportunity to participate in facility-wide planning:

- Participating in treatment team meetings
- Serving on committees
- Participating in town hall meetings
- Sharing ideas with supervisors
- Responding to staff surveys
- Communicating directly with the facility director and other members of the administration

7. Facility leadership has a plan for creating an environment of care that values employees, assures that treatment of consumers is consistent with organizational values.

Staff at all levels indicated that the leadership of the facility is consistently reviewing ways to create an environment of care that values the employees and assures that consumers are treated in a manner consistent with the organizational values of person-centered care, teamwork and respect. The facility has been engaged in a performance

improvement initiative designed to improve communications among all staff, in general, but specifically in clinical communications. The need to develop strategies for increasing communication was identified through a recent staff survey. The facility has also enhanced its employee recognition program. One recent addition to the employee recognition program involves the nomination by peers of employees whose actions are believed to best exemplify "living our values". A panel of judges blindly reviews the nominations and selects the winner(s). The facility has also initiated a week of celebration for each department within the hospital. During that week, each division is recognized for its unique contributions to the facility.

Staff discussed the fact that this facility has a very culturally diverse staff, which is an additional cause for celebration. Events that foster acceptance of and respect for individuals of diverse backgrounds and beliefs are held throughout the year.

All 12 staff members who were interviewed reported feeling valued by the facility administration and their immediate supervisor. The following were cited as examples of how the administration conveys that employees are valued: listening to staff opinions, creating an environment of open communication, expressing appreciation about the quality of staff's work; praising their work both verbally and through memos; and creating special staff functions where the focus is sharing both food and fun.

Administrative staff maintained that respectful treatment of staff translates to respectful treatment of the consumers. It was reported that NVMHI is very invested in creating and supporting a learning culture that highlights accountability and supports staff learning from events that did not go as expected. Opportunities for performance improvement, skill building and retraining emerge from this approach.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

Interviews, a review of the admissions policy and clinical records demonstrated that the facility has a system for assuring appropriate admissions. It is required that a CSB prescreener assess the individual prior to admission to the facility. The prescreener determines whether the consumer meets the criteria for admission to an acute care setting, which is determined by the presence of imminent risk to harm self or others or substantially unable to care for themselves due to a mental illness. In addition, the prescreener assures that there are no less restrictive alternatives to hospitalization available prior to initiating the referral.

Nursing administration indicated that the successful completion of basic medical clearance is an important factor in reviewing the appropriateness of an admission. If any questions arise as a result of the presenting information, the facility physician reviews the preadmission papers before final authorization for admission is determined.

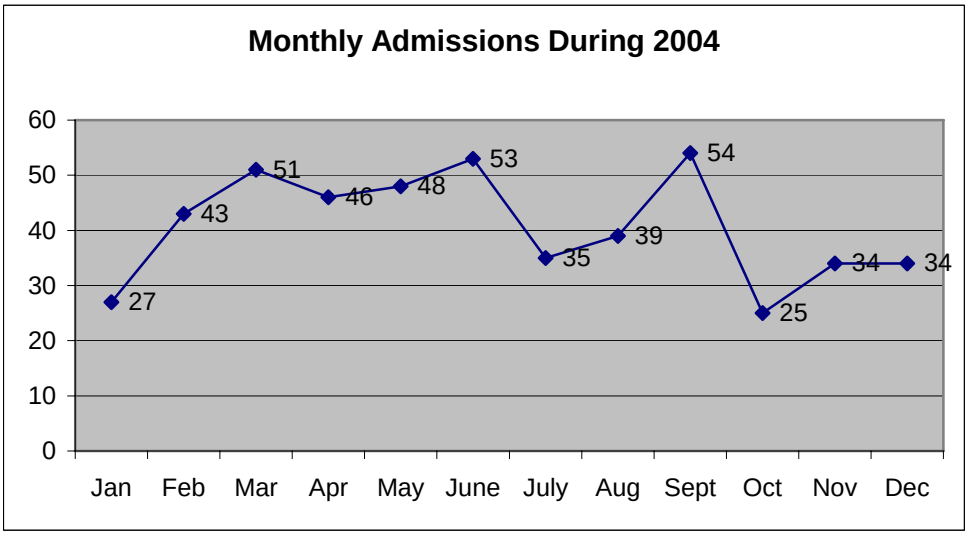
When questions arise regarding whether an individual with a dual diagnosis of mental illness and mental retardation is appropriate for admission, the NVMHI staff consult with the staff of the Northern Virginia Training Center (NVTC). This interagency relationship is described as very cooperative.

Data provided by the facility revealed that there were 491admissions to the facility during calendar year 2004 of which 274 were male and 217 were female. It was reported that the facility received 702 requests for admission during the same time period.

The primary reasons that admissions to the facility were denied included:

- The consumer was determined to be medically unstable and not suitable for admission
- The consumer had private insurance coverage, which resulted in the person being referred and admitted to another facility.
- There was no bed available at the facility. In this event, referrals for admission are made to another state-operated facility, such as Western State Hospital or beds are purchased in a local hospital.

Monthly monitoring data for 2004 reported the admissions as of the 1st day of each month as follows:



2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Administrative staff reported that the facility works cooperatively with the CSB to secure appropriate services when admission to the facility is determined to be inappropriate or not possible due to the census. As previously noted, if the consumer is determined to be appropriate for admission but the facility is full, NVMHI admission staff facilitate

placement at another state-operated facility or initiate purchase of a private bed until a transfer to NVMHI can be arranged.

Service Provision

1. There are systems in place to assure that the consumer receives those services that are linked to his/her treatment plan and identified barriers to discharge.

Each consumer admitted to the facility undergoes a series of assessments by a number of disciplines. A nursing screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours of admission. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These evaluations become the basis for developing the individualized treatment plan. Interviews with clinical staff revealed that the goal of the assessments is to go beyond the formulation of a diagnosis and identify the various skills and supports each consumer will need in order to become fully engaged in community living. The identified skills and supports will be measured in the context of the person's strengths and limitations with a focus on those objectives that are related to "barriers" to the person re-entering the community. An integrated treatment plan is developed outlining interventions to address these barriers during hospitalization. Treatment objectives are formulated with the consumer, family and/or legally authorized representative, and the community liaison during treatment team meetings. The treatment team, the consumer and/or the legally authorized representative discuss active treatment programming options during the treatment planning process.

The facility uses a software program to track each consumer's treatment objectives and matches them to the program options that are available. The person's individual goals are clearly identified so that program facilitators can focus activities on these goals and keep the treatment team informed of progress.

The facility operates a psychosocial rehabilitation (PSR) treatment mall that is designed to provide didactic and experiential opportunities for consumers. Group activities are offered Monday through Friday with leisure activities scheduled during the evening and weekends. A number of the consumers preparing for community re-integration participate in off-site clubhouses or other community-based day treatment programs. Several NGRI (not guilty by reason of insanity) consumers work off-site.

On 2/24/05 OIG staff observed five active programming groups. These included: Conflict Resolution, Insight and Recovery, Discharge Issues, Psychopharmacology and Understanding Your Treatment Plan. Consumers have the opportunity to participate in a variety of treatment options both on-site and in the community.

Four consumers were present at the Conflict Resolution group that was facilitated by a psychiatrist. The facilitator actively engaged the group and provided concrete examples of ways to effectively address conflicts throughout the class.

Only one consumer was in attendance for the Insight and Recovery group. When asked why there was only one consumer in the group, the facilitator explained that the group was specifically designed for consumers at a specific stage in their treatment, which limits the numbers. The OIG was also told that it was the end of a schedule cycle by which time some consumers had dropped out and others had been discharged.

The Discharge Issues group was not held as scheduled because the two facilitators were not present. Seven consumers had arrived to participate in this group. The facility psychosocial rehabilitation director stated that staff is responsible for notifying her when their classes are cancelled. She had not been notified of this cancellation.

A physician led the Psychopharmacology group at which two consumers were present. The purpose of the group was to discuss the purpose and side effects of the medications that were prescribed to the participants. The consumers actively participated in the discussion and openly explored issues regarding their medication usage. The group ended about fifteen minutes early after all the questions were addressed.

The OIG staff had an opportunity to discuss the goals of the Understanding Your Treatment Plan group with the facilitator before the group began. The facilitator related that attendance to the group from the onset had been sporadic. There were 8 consumers scheduled for the group, 2 of which have not participated in any of the sessions. Only one participant was in attendance. No one had shown up the previous week. It was explained that in order to benefit from the group, participants must attend all sessions because the information is presented in a sequential fashion. If participants miss the first four sessions, it is suggested that they drop out unless they can demonstrate that they have mastered the earlier material. The facilitator shared that consumer participation often dwindles at the end of the class cycle. The goal of the class was to review specific treatment plans with consumers, to help them to understand their goals and to assess how well the plan is addressing their needs.

During the time when the group activities were occurring, the OIG staff observed 19 consumers either sitting or sleeping in the dayroom area, 2 were engaged in a conversation with facility staff, 8 were standing in the hallways and 3 were in an area described as a “waiting room” for the male bathroom. One consumer was noted to be using the Snoozilon Room.

2. There are processes in place that support evidence-based practices.

According to the administrative and clinical staff interviewed, NVMHI has a number of processes in place that support evidence based practices. The medical staff monitors medication adherence and effectiveness. The Pharmacy and Therapeutics Committee reviews medication practices within the facility, including the use of PRNs and the use of polypharmacy. Grand Rounds are routinely scheduled, which serves as a way for new knowledge to be made available regarding best practices and established practice standards.

Other practices reported during the interview process included: the use of Dialectic-Behavioral Therapy (DBT), the reduction of seclusion and restraint usage, falls prevention and behavioral support team reviews.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

Interviews with members of the administrative and clinical staff revealed that the facility has been actively involved in increasing staff awareness regarding the effective use of recovery principles within this setting. Training in communication styles that support recovery is one example. Recovery principles are reviewed during new staff orientation and annually. New clinical staff is required to demonstrate competency regarding recovery principles and psychosocial rehabilitation by successfully completing a written test before becoming a group facilitator.

Recovery principles are reportedly most evident in the active treatment programming offered at the Institute. The Director of Psychosocial Rehabilitation programming has attended a number of recovery model training events. NVMHI staff served on the workgroup that planned a regional conference on "Growing Recovery", which took place in September 2004. Consumers are surveyed at the end of each of their groups to determine what was most helpful and also least helpful. Changes are made according to the information received. A number of recovery-oriented groups are offered such as Hope Happens.

It was reported that training in motivational interviewing has been provided to staff at all levels. This technique is designed to aid consumers in becoming increasingly aware of the importance of taking an active role in managing their own lives through establishing personal goals.

The majority of direct care staff who were interviewed stated that they were familiar with some of the recovery principles, however, 5 of the 12 interviewed indicated they had not received specific training on the topic.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

Administrative staff reported that the facility has conducted staff surveys, which include a section on staff perceptions regarding the quality of services provided at the facility. The facility currently conducts consumer satisfaction surveys, and a more broad-based survey is currently in development that will enhance the facility's understanding of the consumers' perception of quality on a number of key indicators. One acknowledged area of weakness is in the facility's understanding of the perception of families and significant others. Families' comments and concerns regarding the scope of services offered

regionally were identified during regional planning meetings, but these were not necessarily specific to the Institute.

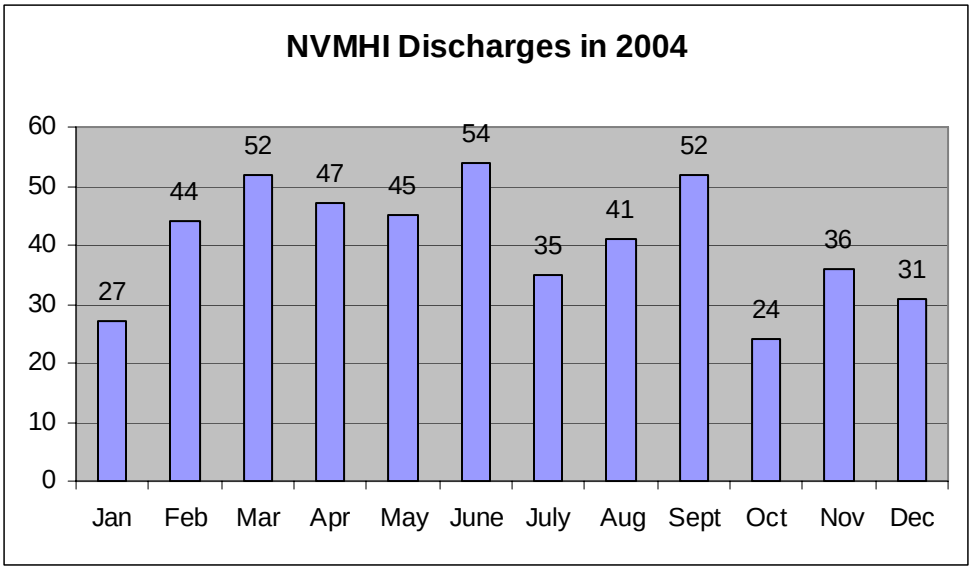
The facility maintains regular contact with representatives from the local community services boards. It was reported that there are opportunities during these contacts for concerns and issues to be discussed. NVMHI has plans to establish a more formalized method for obtaining feedback from the CSBs regarding the quality of the services provided and their satisfaction with the working relationship between the two organizations.

Discharge

1. There are systems in place for effective utilization review and management.

The Utilization Review Committee carries out both utilization review (UR) and utilization management activities. The facility's UR coordinator starts the review process by assuring that the admission was appropriate. Chart reviews are conducted to assure that the documentation adequately reflects the goals of treatments, discharge plans and the on-going justifications for continued hospitalization. Clinical staff, primarily nurses and social workers, evaluates the consumers daily for discharge readiness. The UR committee conducts a case-by-case review of the consumers' length of stay with a focus on facilitating discharge as soon as it is clinically possible. Cases where hospitalization has extended beyond the timeframe initially established by the treatment team are regularly reviewed. It was reported that there were 26 consumers on the extraordinary barriers list at the time of the inspection.

According to the monthly data provided to the OIG by the facility, there were 448 discharges in 2004. The following graph depicts the discharges during that timeframe.



2. There are systems in place to assure that effective communication occurs between the consumer, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the consumer into the community and to prevent re-hospitalization.

Administrative staff reported that contact with the appropriate CSB community liaison regarding begins at the time of admission. CSB staff participate actively in treatment and discharge planning throughout the facility stay. Community based aftercare staff meets with the team social worker and the consumer once a week to discuss issues associated with hospitalization and discharge. Family members, as appropriate, are encouraged to participate in the treatment planning and discharge meetings.

Social workers serve as the primary point of contact between the facility, the consumers, the LAR, the family, and the community. It is the primary responsibility of the facility in partnership with the consumer and/or the LAR to determine the needs of the consumer upon discharge. This information is communicated to the community liaison that is responsible for facilitating the arrangements for service provision, housing and other identified service needs. The liaison also helps to make appointments with community providers. Interviews revealed that effective discharge planning and established community linkages are the best mechanisms for preventing re-hospitalization.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the consumers and is well maintained.

Tours were conducted on all the residential and programming areas within the facility. Overall, the facility was well maintained, clean and odor-free. There are four distinct residential units. The units are co-ed serving consumers at different acuity levels.

Despite the cinderblock walls, the units are very comfortable, homelike and do not look as institutional as some of the other state-operated facilities. The units are painted in soft, cool colors and have attractive carpeting. There are pictures on the walls in the hallways and in the bedrooms. The bedrooms are set up in suites so that two rooms share a bathroom, which have adjoining doors that can be locked for privacy.

Each unit has a laundry room enabling the consumers to do their own laundry. There are both pay phones and a facility phone available for use by the consumers. Each unit except for F unit has a computer room. Each unit had at least one (more for larger units) common room. The common rooms were well lighted. For the most part, furniture in the common areas is arranged in small groups to facilitate interactions. Each unit has access to a courtyard and an outside grassy area.

F unit is used primarily for admissions. Consumers on this unit typically do not go off the unit to the Treatment Mall for PSR programming. Groups are conducted on the unit in a multipurpose room. As most of the activities for the consumers occur on the unit, there

are two common rooms so that the individuals who are not stable enough to actively participate in treatment can have an area in which relax and interact with others.

I-1, I-2 and K units serve consumers who need more intensive longer term care. K unit, the largest unit, houses 44 consumers who are preparing for discharge.

Consumer meals are served in the facility cafeteria, which is a bright, open and well-decorated area. The consumers walk through a serving line to collect their trays. OIG staff had the opportunity to interview 15 consumers during the mealtime. All of the consumers interviewed reported receiving adequate portions of food. Twelve of the consumers described the food as good, although several indicated that there were not enough "fresh vegetables" offered. Five of those interviewed stated that they would like for a salad bar to be offered as an option more often than it is currently.

Administrative staff reported that the most critical capital improvement projects for the facility included the following:

- Upgrading the telephone system at an estimated cost of $300,000
- Environmental needs such as carpeting and acoustical padding for the gym at an estimated cost of $120,000
- Energy control for buildings ABC air handling units at an estimated cost of $59,000
- Purchase of a new vehicle at an estimated cost of $28,900

Administrative staff reported that a roof replacement project has been approved. This project will cost approximately $1,400,000 and is scheduled to begin this summer.

2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Safety at NVMHI is promoted through a number of mechanisms such as environmental checks, on-going inspections, staff training, and the reporting systems established for identifying and monitoring serious incidents, formal/ informal complaints and allegations of abuse and neglect. Administrative staff interviewed maintained that the safety of the consumers, staff and visitors was one of the primary focuses of the facility.

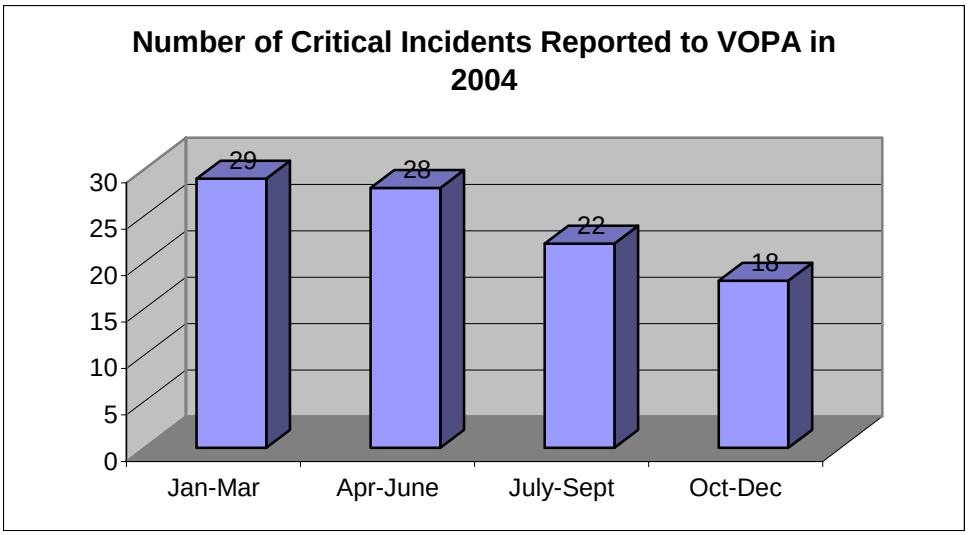
Assuring that safety is reviewed, discussed, and monitored is a function of the Environment of Care (EOC) Committee but is evident in the work of many of the committees and workgroups within the facility. The recent National Patient Safety Goals Fair is one example of how facility workgroups impact safety in the facility environment.. This 10-hour fair was designed to increase staff awareness and knowledge of the safety goals. It was reported that more than 100 staff members attended the fair. A detailed account of the fair was written up in a JCAHO publication. The materials were shared with Western State Hospital for use within that facility.

Building maintenance and safety checks are the joint responsibility of Buildings and Grounds and Campus Security. Routine rounds of all the buildings are made to assure

that all equipment is in good working order and potentially hazardous situations are dealt with before a problem develops. This includes vehicle maintenance. Staff is expected to report any areas that need repair or present a risk as soon as noted. Work orders are created and completed based on the levels of risk involved, with potential life, health and safety code violations attended to immediately.

Staff are trained in key areas that have a direct impact on consumer safety such as fire safety procedures, managing challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data is tracked for trends regarding a number of key indicators such as patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints and incidents of seclusion and restraint usage.

According to the information provided by the facility, there were 97 critical incidents at the facility in 2004. The following graph shows the number of VOPA reportable incidents per quarter in 2004.

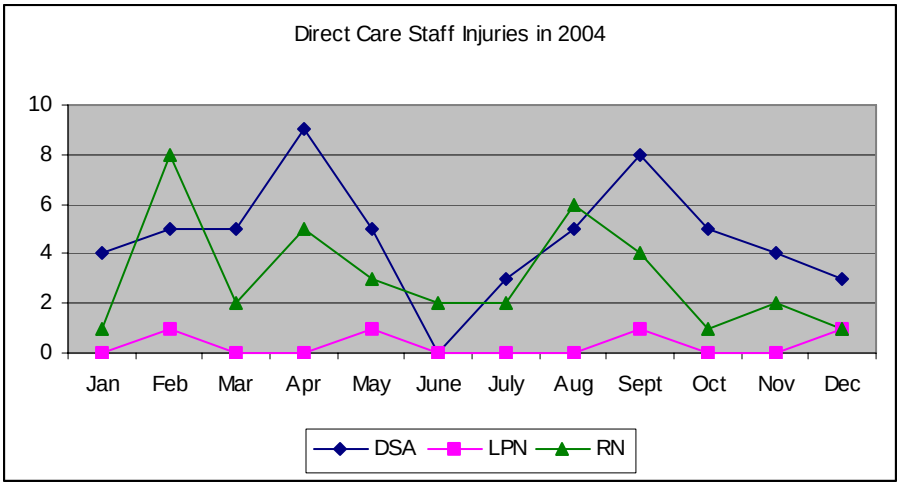


One of the performance improvement initiatives established for the current fiscal year is to improve ways of addressing patient aggression. Nursing staff indicated that the facility has a low threshold for reporting incidents of aggression. Each incident is reviewed both by the treatment team and the facility leadership team in morning meetings. Even though nursing staff confirmed that the majority of incidents of aggression within the facility did not result in an injury to either one or both consumers, there had been an increase in the number of staff injuries associated with consumer acts of aggression. It was also reported that a number of the injuries that were sustained were minor and did not require medical attention.

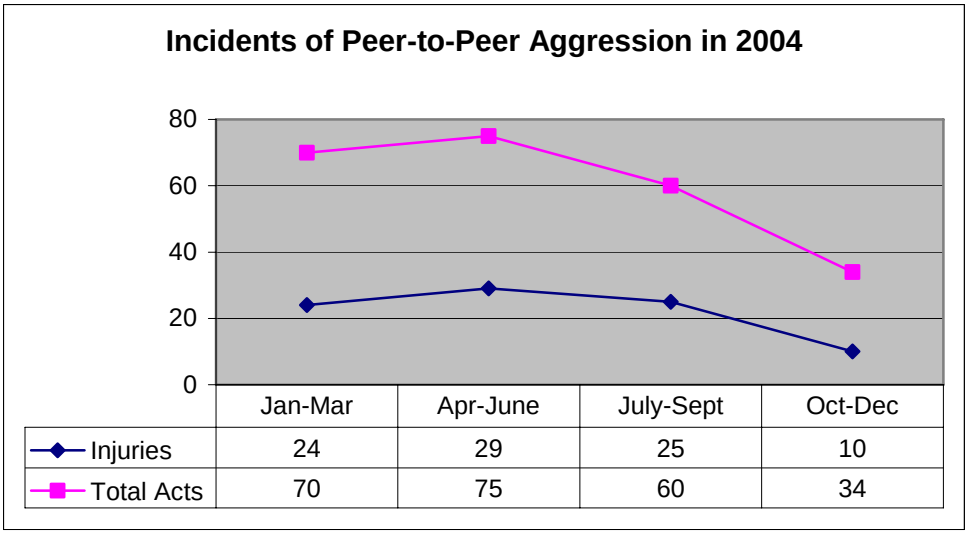
As a result of the performance improvement initiative, a number of strategies were implemented including:

- Strengthen TOVA content around the leadership role in crisis situations.
- Increase staff debriefing opportunities immediately following stressful incidents.
- Installation of an alarm system in the mall area so that staff can respond to an incident quickly.
- Increase early interventions by staff to prevent situations from getting out of hand.
- Increase nursing staffs' presence in the hallways, both on the units and in the mall areas.

The next two graphs provide information regarding the number of reported staff injuries and the number of acts of peer-to-peer aggression within the hospital during 2004. Information provided by the facility indicated that there were 136 reported staff injuries during 2004, of which 107 occurred as a result of an aggressive act by a consumer. The following graph shows the number of incidents of staff injuries ding 2004 for RNs, LPNs and DSAs.



According to the data provided by the facility, there were 259 incidents of peer-to-peer aggression during 2004. Of these incidents, 88 resulted in injuries to one or both of the consumers involved. The following graph shows the total number of incidents and those resulting in injury for each quarter of 2004.



Training is provided to all staff regarding human rights and the reporting of abuse and neglect. There were 24 allegations of abuse and neglect reported in 2004, of which 1 was substantiated following investigation. Consumers and/or their LAR filed 80 formal complaints and 77 informal complaints during 2004.

During 2004, NVMHI had 3 incidents that required the use of seclusion, 13 incidents of physical holds and 61 incidents in which mechanical restraints were used. This number for use of mechanical restraints includes the use of restraints for transport of NGRI consumers.

All of the staff interviewed reported that the facility provides a safe environment that assures the protection and safety of the consumers. The majority (23/28) indicated that adequate staffing patterns is one of the key indicators for a safe environment. Others factors mentioned included:

- Good communication both among the service providers and with the consumers
- Conducting risk assessments and risk prevention activities
- Regular status checks of the consumers
- Facility inspections and drills
- Alert light system used to indicate when extra staff are needed to assist in the management of a situation or crisis

It was reported that staff have discovered contraband in facility that presents potential safety hazards to the facility environment. To address this situation, a team has been assigned to review the problem and make recommendations for correcting it. As a result of this intervention, the incidents of contraband being successfully brought into the facility has decreased significantly.

Only 2 of the 8 consumers interviewed reported feeling safe. Those that indicated feeling unsafe reported that the frequency of incidents of aggression creates a tense environment and the lack of male staff members contributed to their feelings. Five of the consumers

interviewed indicated that the "forced use of medications" added to their not feeling safe and was noted by 8 consumers as the intervention that was least helpful to them. The facility reported that during the last half of 2004, emergency medications were used 327 times. It is not known how often these medications were administered without the expressed consent of the consumer.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

NVMHI has a quality management program. The program is intended to assure that the processes that govern quality within the setting are designed to effectively monitor, analyze and improve patient outcomes.

Interviews revealed that the leadership team believes that a central function of the Quality Management committee is to communicate effectively with staff to assure an understanding of the importance of everyone participating in performance improvement efforts.

The facility has a performance improvement department with 2 FT employees who are dedicated specifically to monitoring quality improvement activities. Quality improvement indicators that have been identified are reviewed at least monthly. These include areas such as medical records documentation, seclusion and restraint use, infection control and a discharge monitor.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

Interviews revealed that there are a number of formal and informal mechanisms in place to help the facility gain an accurate understanding of all the stakeholders perceptions regarding service provision. Facility social workers make calls to members of the community, consumers' families and legal guardians through which an understanding of perceptions is obtained.

In addition, the facility conducts consumer and staff satisfaction surveys. A project is underway to enhance the information received. Meetings are held with referring CSBs to obtain information regarding ways to improve the working relationship between the two organizations in order to improve patient care. The facility leadership described a good working relationship with members of the DMHMRSAS Central Office.

Recommendations

The OIG has the following recommendations regarding Northern Virginia Mental Health Institute as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1: Consumer engagement and participation in the psychosocial rehabilitation programming (PSR) sessions observed was very limited. Attendance at scheduled sessions was also limited. The OIG observed five different PSR groups. One group that was scheduled for 8 participants had only 1 consumer in attendance. Only two consumers were present for another group, but none had shown up the previous week. The facilitators for one group did not show up so the consumers who were present were dismissed. Another facilitator reported that by the end of a programming cycle or term a number of consumers have either dropped out or have been discharged.

Recommendation: It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program. A mechanism should be developed to monitor participation and consistency between the planned program and the services that are actually delivered.

DMHMRSAS Response: The Plan to increase active treatment is as follows:

- *The NVMHI Treatment Mall Council, which is comprised of staff representatives from all disciplines and consumers, has been meeting since March 2005 to determine better ways to address active treatment needs for a changing patient population. As a result of feedback obtained through patient focus groups, planning priorities were identified: enhance opportunities for patients to select their programs, adjust program offerings, and provide more depth of content in key areas.*
- *The Council will be proposing program modifications that are based on different levels of readiness for change and participation in treatment, inclusive of the patient's clinical status. The Council and PSR Director will present their recommendations to the facility Clinical Leadership during the third week of May for final approval. Implementation of approved actions will begin in early June 2005.*

While monitoring mechanisms have been in place at the individual level, a systemic mechanism will be developed to monitor groups/programs. The Psycho-social Rehabilitation (PSR) Director will conduct "walk-throughs" on a regular basis to enhance monitoring of patient participation in programming; and will monitor the consistency between planned programming and what was actually delivered. The PSR Director will forward weekly reports to facility Clinical Leadership to facilitate prompt adjustments when needed.

Finding #2: A majority of the consumers who were interviewed (6/8) reported not feeling safe within the facility. This was based on their perception of the frequency of aggressive acts and the lack of male staff members.

Recommendation: It is recommended that the facility conduct a review of consumers' perceptions regarding safety within the environment. Based on the findings from this review, the facility should develop and implement a plan to improve the safety of the environment so that consumers do feel safe.

DMHMRSAS Response: A critical factor in moving toward consumer empowerment and self-determination is the need for consumer feeling of safety in the environment. The plan to increase patient comfort relative to safety is as follows:

- *In order to better understand patients' perception of personal safety, over the next four weeks the Chief Nurse Executive will dialogue with nursing staff to increase sensitivity to patients' sense of safety. Dialogue will include the expectation that nursing staff will assess individuals and groups for the need for supportive interventions to promote feelings of safety when unsettling events occur in the milieu.*
- *The Director of Psychology, in collaboration with the Behavior Team, will develop an array of resources for patients and staff to utilize to support individuals in the management of stress, anxiety and agitation that could result in unsafe behaviors. Dissemination of materials is planned by the end of June 2005.*
- *NVMHI will conduct a comprehensive patient satisfaction survey, which includes questions on consumers' perceptions regarding safety, by the end of June 2005. Based on the findings, additional actions, as indicated, will be developed and implemented.*